

Clinical staff can find themselves in a position where they can influence practice by leading on change. First, they need to be clear on exactly what needs to change

# Leading change: 1 – identifying the issue

## In this article...

- Concepts of change management
- How to contribute to and manage a safe environment through change, quality assurance and risk management
- Learn different approaches to change management and how to apply them to practice

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**Abstract** Kerridge J (2012) Leading change: 1 – identifying the issue. *Nursing Times*; 108: 4, 12-15.

To enable sustainable change, nurses need to take the lead in managing it.

Recent national initiatives have emphasised the importance of frontline staff in service improvement. The ability to influence and manage change has been identified as an essential skill for delivering new models of care.

This article is the first in a three-part series designed to help nurses at all levels develop the knowledge and skills they will need to initiate and manage change.

This article focuses on identifying what needs to be changed and why.

There is a pressing need for nurses to participate and, in many circumstances, take the lead in managing change in clinical practice to improve the quality of care.

The importance of the role of frontline staff in service improvement is emphasised in the NHS Leadership Framework (National Leadership Council, 2011). This identifies the ability to influence and manage change as essential skills for delivering new models of care.

The NHS Service Delivery Organisation

(SDO) has issued guidance on developing change management skills for health professionals and managers (Iles and Cranfield, 2004). This aims to help those leading change in healthcare to understand the concept of change management and explore the application of theory and models in their own area of practice.

The NHS Institute for Innovation and Improvement has produced Improvement Leaders' Guides (NHSI, 2008) to support the implementation of change at the front line of healthcare.

However, both these resources seem to suggest that those leading change should be in a post with a formal management element. If this is the case, the majority of healthcare workers are denied the opportunity to make a difference to patient care through changing practice.

The NHS Leadership Framework (NLC, 2011) recognises the potential of all staff to contribute to service improvement, irrespective of discipline, role or function. It advocates developing the skills of the entire workforce in leading improvement and innovation to create a climate of continuous service improvement.

However, while most people have the potential to lead in a particular situation they may not have the confidence to do so, as they may lack the knowledge of the theory and tools to help them when the opportunity arises.

This series is aimed at those

## 5 key points

1 There is a pressing need for nurses to participate in or lead change management projects

2 Staff need to be encouraged to develop the knowledge and skills to influence change

3 The first step is to identify what exactly needs to change and why

4 Several tools exist to help this process, including root cause analysis and process mapping

5 Stakeholders need to be identified and involved in the process of change for it to be successful



## ***“There is so much scope in nursing – believe it is all possible”***

Janet Davies ➤ 26



Change could stop delayed discharge

people – clinical staff getting on with the day job – who suddenly find themselves in a position to influence practice by leading their colleagues in a situation that needs to change.

### **Identifying the change**

There are three elements involved in identifying change:

- » What needs to be changed and why?
- » Who will help you do it?
- » How to identify the problem – root cause analysis, cause and effect, and process mapping.

### **What needs to be changed and why?**

Coming up with a problem is not usually difficult – every day, nurses complain about some aspect of their work. However, it is often difficult to pinpoint exactly what is wrong and coming up with a solution to put it right.

The first step is simply to clarify what needs to be changed and why; make sure you are clear how the change will result in an improvement.

You can do this by comparing what is it that you want to happen against what is happening now, then asking yourself the following questions:

- » Could we do more work in the same time (efficiency)?
- » Could we do our work better (effectiveness)?
- » Could we save money (economy)?

It is a good idea to take baseline measurements for the issues you want to improve, as these will help you to track your progression. The measurements may relate to: time or delays; number of steps; patient satisfaction; and/or costs or resources used.

You will need to be able to prove that the change has been effective and you may not be able to do that if you do not know where you started.

Once you have this reasonably clear in your own mind you will need to engage others to support your ideas and champion the change. This involves getting a few key

like-minded people on board. The views of others will be invaluable in giving different perspectives, and you will need support in implementing any proposed change.

These individuals may form the core of your project team, so pick them wisely. They should be: people who are committed to the change, so they will be motivated and enthusiastic; people who can help make it happen, as they will have expertise and carry influence; and, importantly, people with whom you can work, to minimise destructive conflict.

Once you have this core group of perhaps four or five people, you will need to look at the roles each of you will take. Who is leading the change – do you need a leader, or will you all be able to collaborate and share leadership? If the group is small and you already have experience of working together in this way, collaboration may be a workable option. Alternatively, you may decide to each lead a part of the change.

If you do decide that the project needs a leader, who will take this role – is it you? Are you the best person for the job? Hopefully, the answer will be yes but, if it is not you this time, just working within a small project team supporting the change will give you valuable experience and confidence to take on the management of a change in the future.

Once leadership has been decided, you can allocate other important roles, such as the recorder of decisions and the organiser of future events. These posts need to be filled by the right people or chaos can ensue.

### **Stakeholder analysis**

You need to identify everyone who is an interested party in the proposed change. With your core group, draw up a list of all the people or groups likely to be affected by the change. This may include, for example, managers and commissioners, colleagues, service users, collaborators, competitors or customers.

Once the list is complete, you can analyse it in terms of power, influence and

impact (Table 1). This matrix can be extended if a large number of stakeholders need to be considered.

Stakeholders in the “manage” section should be invited to participate in further activities where possible.

It is useful, at this point, to have some idea whether your key stakeholders are for or against your proposed change, so ask them. People are usually open about their views and this will give you the opportunity to explain your rationale and try and win them over. Even if you gain all stakeholders’ support, you will at least know if you have some opposition and have the opportunity to examine their objections – they may have a point and you would be foolish to ignore them.

Once you have got a core group and identified your stakeholders, you will need to get them together.

Maurer (2010) advocates giving other people a significant voice in planning and implementing the change, as this will reduce confusion, get them thinking about solutions and increase commitment and ownership.

If this can be done in the form of a workshop, it puts everyone on an equal footing. If it cannot, gather ideas in whatever way you can. One-to-one meetings may be the most productive but questionnaires are also useful and less time consuming. If you can combine methods, with one-to-one meetings or questionnaires taking place after initial workshops, you may be able to target the questions more carefully.

### **Root-cause analysis**

Organise a workshop (or more than one if you have a large number of stakeholders), giving plenty of notice. If you need to hold more than one, vary the time and day of the week, to maximise opportunities for attendance.

Once you have your stakeholder group together, state the problem as you see it, without offering any solutions, then ask group members for their opinions to try

**TABLE 1. STAKEHOLDER POWER, INFLUENCE AND IMPACT (NHSI, 2008)**

	Satisfy	Manage
High power	Keep opinion formers satisfied and informed	Key stakeholders who should be fully engaged
	Monitor	Inform
Low power	This group may be ignored through lack of time and resources	Increase influence if possible – patients and colleagues often fall into this category
	Low impact/ stakeholding	High impact/stakeholding

# Nursing Practice Discussion

clarify exactly what the problem is. At this point, you may get a long list. However, it is likely that these can be linked together by theme, each with a potential solution of its own.

After you have identified all the problems or themes, go back to each one and ask the group why this is happening. Write down their answers. If these do not give a solution to the problem, ask why again, and drill down from answer to answer, asking why, until you get to the real cause (five is the rule of thumb but more or fewer may be needed). Table 2 gives an example of this process.

You are now doing a root-cause analysis using the Five Whys Tool (Senge et al, 1994). This allows you to clearly define the problem and describe it accurately (Ammerman, 1998). Without clarity, there

is a danger of wasting valuable time focusing on symptoms without resolving the problem. For example, if the problem is that you are having too many delayed discharges because you are not able to discharge patients home in a timely fashion, one of the reasons may be that the arrangements take much longer than anticipated (Table 2).

If, at any point in the root cause analysis, it becomes obvious that there is more than one possible answer to the "why?", you can continue with an analysis of each answer. They may lead you in the same direction or may identify another problem to be solved.

## Cause and effect

If you have difficulty identifying the causes of the problem, you may want to use a cause-and-effect tool, commonly

known as a "fishbone" diagram (Fig 1). This can help you to fully understand a problem by detailing all the possible causes, not just the most obvious ones, and allows you to focus on the content of the problem rather than its history.

Process mapping enables you to identify bottlenecks and other problem areas. It works well when considering a patient journey or care pathway and will also work when looking at a specific process.

There are two stages to process mapping. First, understand what happens, where it happens and who is involved. Second, examine the process map to determine where there are problems.

The first stage involves mapping what happens at a high level (Fig 2), identifying the journey with a clear start and finish point. Make sure you map what actually

TABLE 2. EXAMPLE OF USE OF FIVE WHYS TOOL

### Why aren't we able to discharge patients home within a reasonable time frame?

Because arrangements take much longer to organise than we expect

### Why do they take so much longer?

Because we underestimate the complexity of the job and do not start planning early enough

### Why do we underestimate the complexity of the job?

Because we do not fully understand each stage needed to complete discharge and the time required by others involved in the process

### Why don't we understand this?

Because we haven't discussed it with other staff or agencies involved, and don't have a plan in place to act as a prompt for forward planning

### Why not?

Because it is not the responsibility of any one person to do this

**So the root cause is that no one has developed a discharge form that identifies time frames for the stages involved based on actual information from the other people involved. If you simply treat the symptom by starting discharge planning earlier, without a plan or without any discussion, the problem is likely to recur.**

FIG 1. CAUSE AND EFFECT TOOL

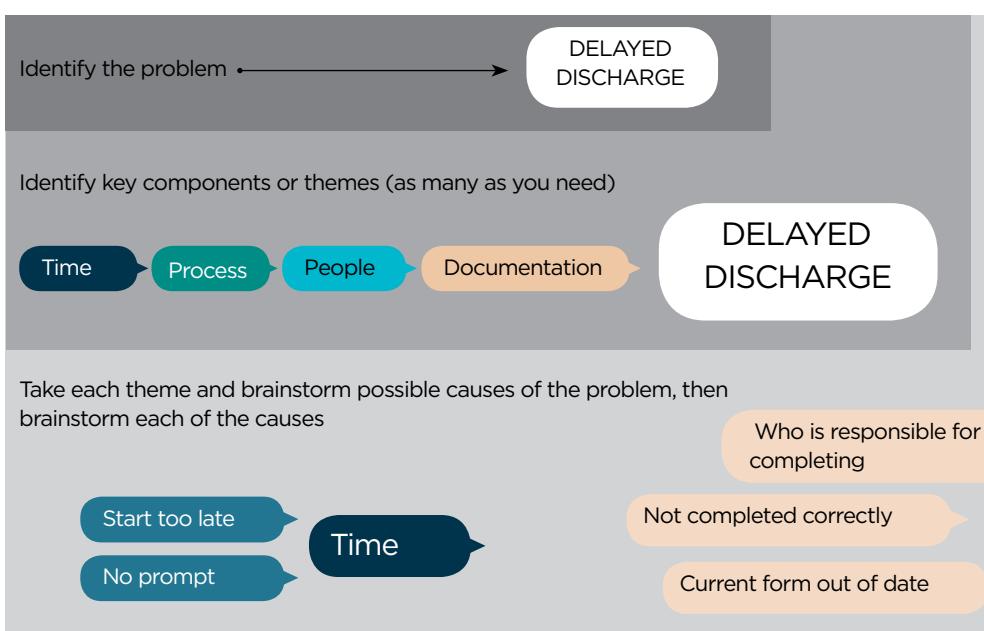
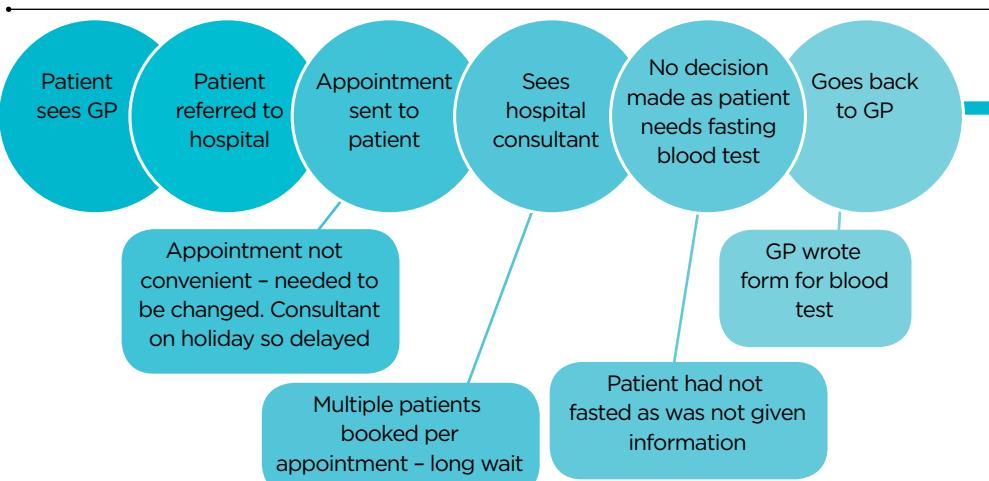


FIG 3. EXAMPLE OF DETAILED MAPPING



happens rather than what you want to happen, and only map the process you have chosen to improve.

The second stage is to analyse the map, to examine why situations happens in that way, where the problems are and how the process can be improved (Fig 3). Putting lining wallpaper or flip-chart paper on the wall to draw the whole process on, using sticky notes to identify details of any variations, problems or solutions, is an easy way of recording the steps on the journey.

Once you have mapped the process and identified the root cause of a problem, you will probably find that you have started to identify possible solutions.

If you have your captive audience at a workshop, you can get them into small groups and ask them to come up with workable ideas themselves. This will

ensure their engagement and ownership of the changes, as they will be proposing them (Anderson 2010).

When the groups have finished, compare their responses and identify what you are going to take forward as possible projects for change. Ideally, your change should include short-term projects as well as medium or long-term projects, or you may be at risk of losing staff motivation and interest. If people do not see some results of their labours fairly quickly, they can lose faith in the project and you will hear the common cry "we did all that work but nothing happened".

Once you have identified your project or projects, you are then ready to move forward.

The next article in this series will look at planning the change. **NT**

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**FIG 2. EXAMPLE OF HIGH-LEVEL PROCESS MAP**

